

Account number

Employee Information: After completed make a copy of Page 1 and Page 2 for your records.

Your name (last, first, middle initial)		Home phone number	Social security number
Home address (street)			
City	State	ZIP code	
Date of birth (mo/day/year)	Company name		

Health Information for All Coverages Being Applied for

Answer only for those individuals requesting coverage. To prevent delays answer each question and give full details to "yes" answers. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height ___ ft. ___ in. weight ___ lbs. Spouse's height ___ ft. ___ in. weight ___ lbs.

1.	yes	no	Is any person on whom coverage is requested currently receiving medical treatment, taking medication, or pregnant?																				
2.	yes	no	In the past 5 years , has any person on whom coverage is requested had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment?																				
3.	yes	no	<p>In the past 5 years, has any person on whom coverage is requested been diagnosed with or received treatment for any of the following (<i>check all that apply</i>)?</p> <table style="width: 100%; border: none;"> <tr> <td>cancer</td> <td>liver disorder</td> <td>bone disorder</td> <td>mental disorder</td> </tr> <tr> <td>tumors</td> <td>kidney disorder</td> <td>joint disorder</td> <td>nervous disorder</td> </tr> <tr> <td>heart condition</td> <td>muscle disorder</td> <td>urinary disorder</td> <td>diabetes</td> </tr> <tr> <td>high blood pressure</td> <td>multiple sclerosis/ neurological disorder</td> <td>respiratory disorder</td> <td>hepatitis</td> </tr> <tr> <td>stroke</td> <td></td> <td></td> <td></td> </tr> </table>	cancer	liver disorder	bone disorder	mental disorder	tumors	kidney disorder	joint disorder	nervous disorder	heart condition	muscle disorder	urinary disorder	diabetes	high blood pressure	multiple sclerosis/ neurological disorder	respiratory disorder	hepatitis	stroke			
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heart condition	muscle disorder	urinary disorder	diabetes																				
high blood pressure	multiple sclerosis/ neurological disorder	respiratory disorder	hepatitis																				
stroke																							
4.	yes	no	In the past 10 years , has any person on whom coverage is requested been treated for, diagnosed as having or tested positive for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune disorder?																				

Provide details for all "yes" answers. If more space is needed, attach a separate page giving full details. Sign and date all pages.

Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition	Type of treatment/names of all medications	
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		

Health Information for All Coverages Being Applied for (continued)

Name	Date diagnosed/treated	Duration of illness or condition
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Diagnosis of illness or condition	Type of treatment/names of all medications
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Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Name	Date diagnosed/treated	Duration of illness or condition
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Diagnosis of illness or condition	Type of treatment/names of all medications
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Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life is not liable for anyone's claim which happens or begins before the effective date of coverage or approval of any life and disability coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions and/or material misrepresentation regarding age or health information could cause life and disability coverages, if issued, to be cancelled as never effective. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I understand all policy provisions for medical coverage will apply. If approved for life and disability coverages, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- For life and disability coverages, I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal life, its agents and employees performing business transactions, any such data.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for life and disability coverage. This information will not be used for any purposes prohibited by law.

Employee's signature	Date signed
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Spouse's signature*	Date signed
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*Spouse signature only required if Voluntary Term Life coverage is elected.